

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/29/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155786</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>09/22/2015</b>	
NAME OF PROVIDER OR SUPPLIER  <b>ALLISONVILLE MEADOWS</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>10312 ALLISONVILLE RD</b> <b>FISHERS, IN 46038</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the Investigation of Complaint IN00176650 and IN00175716 completed on August 7, 2015.</p> <p>This visit was in conjunction with a PSR to the Investigation of Complaint IN00179129 completed on August 7, 2015.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00180481, IN00181438, and IN00181352.</p> <p>Complaint IN00176650 - corrected Complaint IN00175716 - corrected</p> <p>Survey Dates: September 17, 18, 21 and 22, 2015</p> <p>Facility number: 012466 Provider number: 155786 AIM number: 201014060</p> <p>Census Bed Type: SNF: 19 SNF/NF: 115 Total: 134</p> <p>Census Payor Type: Medicare: 19 Medicaid: 92 Other: 23 Total: 134</p> <p>Allisonville Meadows was found to be in compliance with 42 CFR Part 483 , Subpart B and 410 IAC 16.2-3.1 in regards to the Post</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 Survey Revisit (PSR) to the Recertification and State License Survey and to the investigation of Complaint IN00176650 and IN00175716.  Quality review completed by 30576 on September 25, 2015.	{F 000}			